IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-4

JASPER F. WILLIAMS AND EUGENE F. DIAMOND,

v. *Appellants*

DAVID ZBARAZ, *et al.*,

_____ *Appellees*

No. 79-5

JEFFREY C. MILLER, ACTING DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID,

v. *Appellant*

DAVID ZBARAZ, *et al.*,

_____ *Appellees*

No. 79-491

UNITED STATES OF AMERICA,

v. *Appellant*

DAVID ZBARAZ, *et al.*,

_____ *Appellees*

On Appeals from the United States District Court for the Northern District of Illinois

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BRIEF OF *AMICI CURIAE* PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, INC., AMERICAN PUBLIC HEALTH ASSOCIATION, NATIONAL ABORTION FEDERATION, AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS AND THERAPISTS, SOCIETY FOR ADOLESCENT MEDICINE, ASSOCIATION FOR WOMEN IN PSYCHOLOGY, NATIONAL URBAN LEAGUE, INC., THE AMERICAN JEWISH CONGRESS, AND CERTAIN MEDICAL SCHOOL DEANS, PROFESSORS AND INDIVIDUAL PHYSICIANS IN SUPPORT OF THE APPELLEES

(Names of Individual *Amici* appear within)

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-4

JASPER F. WILLIAMS AND EUGENE F. DIAMOND,
Appellants
v.
DAVID ZBARAZ, *et al.*,
Appellees

No. 79-5

JEFFREY C. MILLER, ACTING DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID,
Appellant
v.
DAVID ZBARAZ, *et al.*,
Appellees

No. 79-491

UNITED STATES OF AMERICA,
Appellant
v.
DAVID ZBARAZ, *et al.*,
Appellees

On Appeals from the United States District Court for the Northern District of Illinois

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BRIEF OF *AMICI CURIAE* PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, INC., AMERICAN PUBLIC HEALTH ASSOCIATION, NATIONAL ABORTION FEDERATION, AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS AND THERAPISTS, SOCIETY FOR ADOLESCENT MEDICINE, ASSOCIATION FOR WOMEN IN PSYCHOLOGY, NATIONAL URBAN LEAGUE, INC., THE AMERICAN JEWISH CONGRESS, AND CERTAIN MEDICAL SCHOOL DEANS, PROFESSORS AND INDIVIDUAL PHYSICIANS IN SUPPORT OF THE APPELLEES

Planned Parenthood Federation of America, Inc., Association of Planned Parenthood Physicians, Inc., American Public Health Association, National Abortion Federation, American Association of Sex Educators, Counselors and Therapists, Society for Adolescent Medicine, Association for Women in Psychology, National Urban League, Inc., The American Jewish Congress and 263 medical school deans, professors and individual physicians respectfully submit this brief as *amici curiae* in support of the appellees. All parties have given their consent for the filing of this brief in letters filed with the Clerk of this Court.

INTEREST OF AMICI

Planned Parenthood Federation of America, Inc.

Planned Parenthood Federation of America, Inc., also known as Planned Parenthood—World Population ("Planned Parenthood"), is a not-for-profit corporation organized in 1922 and existing under the laws of the State of New York. Its headquarters are in New York City. It is the leading national voluntary public health organization in the field of family planning.

Planned Parenthood has 187 affiliates in forty-three states and the District of Columbia, all of them separate not-for-profit entities. These affiliates operate approximately 744 family planning clinics offering services to the public. Most affiliates offer medical services, including thirty-six which offer abortion services as part of their program. Eight affiliates are educational units without medical services. Most Planned Parenthood affiliates which do not perform abortions themselves offer pregnancy counseling and referral services.

Planned Parenthood provides its affiliates with guidance in the areas of contraception, voluntary sterilization, infertility, abortion, sex education and education for marriage and parenthood. Each of the affiliates offering medical services functions under strict medical standards promulgated by the National Medical Committee in conjunction with local medical committees. These committees are made up of health professionals, the large majority of whom are physicians.

Planned Parenthood also functions as a clearinghouse for information and services relating to these same areas. It formulates medical and clinical standards which are available to its affiliates and to the public on a nationwide basis and develops guidelines and materials relating to public and professional education in all aspects of family planning. Its Medical Director and other consultants confer with other national medical organizations, medical school faculties and local agencies in relation to teaching techniques, formation of clinics and the like.

Many of Planned Parenthood's affiliates operate in cooperation with local public health facilities. The affiliates are also teaching and training centers for physicians, nurses, teachers and social workers from this country and foreign countries and provide referral services for their clients to qualified medical specialists and facilities.

As a necessary corollary of its activities in the area of contraception, Planned Parenthood is committed to the principle that safe abortions should be available to all who need them. Planned Parenthood does not view abortion as an alternative to contraception; it believes, however, that abortion services are essential to protect women where contraception has been unavailable, has not been used for some other reason or has failed, particularly in cases where pregnancy poses significant health risks. It believes, moreover, that for women who need but cannot afford abortions, public funds must be made available to provide this essential service.

Association of Planned Parenthood Physicians, Inc.

Planned Parenthood works closely with the Association of Planned Parenthood Physicians, Inc. ("APPP"), a New York not-for-profit corporation organized in 1974. APPP is the successor to the American Association of Planned Parenthood Physicians, an unincorporated association which was organized in 1963. APPP was formed for scientific, educational and charitable purposes and specifically to promote the ongoing interest in family planning in order to improve the stability and health of the family through responsible parenthood. APPP has 807 members, all of whom are physicians or other health professionals associated with family planning.

American Public Health Association

The American Public Health Association is a national nongovernmental organization established in 1872. Its object is to protect and promote personal and environmental health. With a membership of over 50,000, it is the largest public health organization in the world. Within this membership, both professional health workers and consumers act in a leadership role to develop a national policy for the provision of equitable, quality health care for all citizens.

National Urban League, Inc.

The National Urban League, Inc. is a charitable organization, organized as a not-for-profit corporation under the laws of the State of New York. As the oldest nonprofit, nonpartisan human rights organization in the nation, the League has waged a 70-year campaign against poverty, racism, illiteracy and neglect.

As a result of its ongoing efforts to ameliorate prevailing conditions in black ghettos, the League is painfully aware of the unacceptably poor health of many black Americans. Maternal morbidity and mortality rates among black women, and particularly among black teenagers, are significantly greater than the national averages. The League believes that the availability of abortions to all black women who are in medical need of them is critical to its efforts to reduce maternal morbidity and mortality among black women.

National Abortion Federation

The National Abortion Federation is a national, nonprofit organization composed both of professional individuals and groups providing abortion services and of others committed to making safe, legal abortion available to all women.

American Association of Sex Educators, Counselors and Therapists

The American Association of Sex Educators, Counselors and Therapists is a national nonprofit membership organization founded in 1967. Its aims are to assist those professionals responsible for sex education, counseling and therapy programs by providing standards of competency in these areas.

Society for Adolescent Medicine

The Society for Adolescent Medicine is a national organization of providers of health care to the adolescent population. It consists of 800 members, all of whom are physicians and health professionals.

Association for Women in Psychology

The Association for Women in Psychology is a not-for-profit scientific and educational organization which encourages research directed toward alternatives to stereotyped sex roles. It has over 2,000 members, women and men.

The American Jewish Congress

The American Jewish Congress, a national organization of American Jews, was founded to protect the fundamental freedom of Jews and all Americans. The American Jewish Congress neither favors nor opposes abortion but believes that a woman's decision whether to undergo abortion must be her own, uncoerced by government. For that reason, it has joined in briefs *amici* submitted to this Court in *Roe* v. *Wade*, 410 U.S. 113 (1973), *Doe* v. *Bolton*, 410 U.S. 179 (1973), and *Poelker* v. *Doe*, 432 U.S. 519 (1977).

Individual Physicians, Professors, and Medical School Deans

The 263 individual physicians who as *amici* subscribe to this brief are all involved in the provision of health care to pregnant women, either as specialists in obstetrics and gynecology, psychiatry or pediatrics, or as educators responsible for the training of medical students and residents in these fields. They are concerned that abortion services not be denied to any women who are in medical need of them, regardless of their economic status.

Amici all share a longstanding concern with the availability of quality medical care to all pregnant women. Through their various activities and efforts, they all seek a decrease in maternal morbidity and mortality. While modern medicine has an arsenal of techniques which can minimize the health risks of pregnancy, too many women, particularly poor women, still suffer severe complications and too many women still die during pregnancy.

As organizations long concerned with maternal health and as individual professionals specializing in the provision of health care to pregnant women, *amici* are in a unique position to address the special health risks which many poor women face in pregnancy and to highlight for the Court the circumstances in which physicians may conclude that abortions are medically necessary. This brief addresses these points and argues that Illinois' denial of funding for indigent women in medical need of abortions violates the Equal Protection Clause of the Fourteenth Amendment.

SUMMARY OF ARGUMENT

Illinois has chosen to deny funding for any abortion which a woman's physician deems to be "medically necessary" but which her physician cannot certify to be "necessary for the preservation of the life of the woman." By doing so, the state has carved out an exception to its policy of funding all medically necessary services, procedures and operations pursuant to the Medicaid statutory scheme.

The District Court correctly found that there is a class of indigent women for whom abortions are medically necessary, even though not certifiably necessary to preserve their lives, and that the state's failure to fund such abortions will substantially increase morbidity and mortality among the women in this class. The medical evi-

dence supports the conclusion that both pre-existing conditions and complications that arise during pregnancy may make an abortion medically necessary, because they may entail excessively high risks that cannot be sufficiently reduced except by the performance of an abortion. Each woman's physician must be permitted, in the exercise of his best professional judgment, to weigh the various treatment alternatives and determine whether an abortion is medically necessary for her, under all the circumstances.

By treating medically necessary abortions differently from other medically necessary services, Illinois has created a classification that violates the Equal Protection Clause of the Fourteenth Amendment. Because the classification unduly burdens the exercise of a fundamental right by withholding funding for medically necessary abortions and thereby imposing excessive health risks on indigent women who seek such abortions, and because for many indigent women the classification acts as a complete barrier to the effectuation of the fundamental right to choose to have an abortion, the classification should be subjected to strict scrutiny. Regardless of whether it is subjected to strict scrutiny or is merely tested against the rational basis standard, however, the classification is not sufficiently supported by any legitimate state interest to withstand equal protection analysis.

ARGUMENT

In *Maher* v. *Roe*, 432 U.S. 464 (1977), this Court held that the Equal Protection Clause of the Fourteenth Amendment is not violated by a state regulation that fails to provide Medicaid funding for a "nontherapeutic" abortion—an abortion sought by a woman on a purely elective basis rather than on the basis of her physician's opinion that an abortion is medically necessary. As the Court pointed out in *Maher*, however, the Connecticut regulation at issue there *did* provide Medicaid funding "for first trimester abortions . . . that are 'medically necessary' . . . ." *Id.* at 466.

The Illinois statute at issue here [1] is significantly different in two respects. First, the Illinois statute denies Medicaid funding for all abortions except those "necessary for the preservation of the life of the woman." [2] Unlike the Connecticut regulation in *Maher*, the Illinois statute thus denies funding for every abortion which a woman's physician deems to be "medically necessary" but which the physician cannot certify to be "necessary for the preservation of the life of the woman." Second, the Illinois statute is part of a statutory scheme which provides funding for all "medically necessary" services and operations other

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[1] Ill. Rev. Stat. ch. 23, §§ 5-5, 6-1, 7-1 (Supp. 1978). These *amici* take no position with respect to the argument raised by the United States that, insofar as the District Court held the so-called "Hyde Amendment" unconstitutional, its judgment should be vacated on the ground that there is no case or controversy with respect to that provision. *See* United States Brief at 26-29. If the Court rejects that argument and considers the constitutionality of the Hyde Amendment, however, these *amici* respectfully submit that the Hyde Amendment violates equal protection for essentially the same reasons set forth in the Argument herein with respect to the Illinois statute. *See, e.g.*, Weinberger v. Wiesenfeld, 420 U.S. 636, 638 n.2 (1975); Buckley v. Valeo, 424 U.S. 1, 93 (1976).

[2] Ill. Rev. Stat. ch. 23, §§ 5-5, 6-1, 7-1 (Supp. 1978).

than abortions, regardless of whether those services are necessary for the preservation of the life of the patient.[3]

The issue presented in this case is thus one of first impression, *i.e.*, whether a state which funds other medically necessary services for indigent patients may withhold funding for an abortion which an indigent woman's physician has determined to be medically necessary.

The District Court ruled that Illinois may not withhold such funding. This conclusion rests on several findings of fact which, as we show in Part I below, are supported by the medical evidence in the record, as well as by recognized medical treatises. On the basis of those findings, the District Court upheld the plaintiffs' contention that "by imposing restrictions on the public funding of medically necessary abortions which are not imposed on other medically necessary operations, P.A. 80-1091 [the Illinois statute] violates their rights to equal protection of the laws guaranteed by the Fourteenth Amendment to the United States Constitution." *Zbaraz* v. *Quern*, 469 F. Supp. 1212, 1216 (N.D. Ill. 1979). For the reasons set forth in Part II, *infra*, the District Court was, we submit, clearly correct in reaching this conclusion.

I. THE DISTRICT COURT CORRECTLY FOUND THAT THERE IS A CLASS OF INDIGENT WOMEN FOR WHOM ABORTIONS ARE MEDICALLY NECESSARY AND THAT THE STATE'S DENIAL OF ABORTION FUNDING FOR SUCH WOMEN WILL SUBSTANTIALLY INCREASE MORBIDITY AND MORTALITY AMONG THE WOMEN IN THIS CLASS.

The District Court's decision rests on three important and interrelated findings of fact. First, the District Court found that there exists a class of pregnant women eligible

[3] By contrast, no claim was made in *Maher* that the regulation which denied funding for nontherapeutic abortions was part of a regulatory scheme which provided public funding for other nontherapeutic services.

for Illinois medical assistance programs for whom abortions are medically necessary but not certifiably necessary for the preservation of their lives. 469 F. Supp. at 1213 n.1, 1218-21. Second, the court found that this class of indigent women cannot obtain publicly funded abortions under the restrictions imposed by the Illinois statute. *Id.* at 1220-21. Third, the court found that the effect of the statute will be substantially to increase morbidity and mortality among the women in this class (*id.* at 1220); or, as the court also put it, a woman within this class "may be subjected to considerable risk of severe medical problems, which may even result in her death." *Id.* at 1219.

As we show below, each of these findings is fully supported by the medical testimony in the record and by the writings of respected medical experts, many of which were made part of the record as attachments to affidavits of medical witnesses.[4]

A. There Exists A Class Of Indigent Women For Whom Abortions Are Medically Necessary.

It is undisputed that some women experience serious medical problems during pregnancy which subject them to greater than normal risk of morbidity and mortality. Women who have pre-existing conditions such as cancer, heart disease or diabetes, for example, or who develop pregnancy-related complications such as preeclampsia, are considered high risks during pregnancy. Whether the risks to health and life in any given case are such that an abortion is medically necessary is, perforce, a medical question. As this Court recognized in *Roe* v. *Wade*, 410 U.S. 113, 166 (1973), "the abortion decision in all its

[4] Testimony contained in the Appendix will be cited by the last name of the affiant, a Roman numeral if the affiant submitted two affidavits, and the page of the Appendix at which it appears; *e.g.*, Depp Aff. I ¶ ——, App. p. ——.

aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician."

This Court has repeatedly emphasized, moreover, that the determination whether an abortion is medically necessary can be made by a woman's physician only after consideration of an array of variables and that her physician must be given the freedom necessary to evaluate these variables and to formulate his best medical judgment:

> "Whether 'an abortion is necessary' is a professional judgment that . . . may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment." *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973), *as quoted in Beal* v. *Doe*, 432 U.S. 438, 441 n.3 (1977).

See also Colautti v. *Franklin*, 439 U.S. 379, 387-88 (1979).

The degree of risk a given woman faces can only be measured against the "normal" risks of pregnancy. Pregnancy inherently involves some risk, because it results in significant physiological changes in a woman's body and places exceptional demands on her bodily functions. General morbidity and mortality rates bear this out.[5]

Obviously, however, a woman's physician must be alert for indications that she, in particular, is at greater than normal risk by reason of a pre-existing condition, such as hypertension, diabetes, heart disease, or cancer, or by reason of a pregnancy-related complication, such as pre-eclampsia. Even for a woman who does suffer from such a disease or complication, moreover, the decision whether an abortion is medically necessary will depend on a number of factors.

[5] *See* Cates & Tietze, *Standardized Mortality Rates Associated with Legal Abortion: United States 1972-1975*, 10 Family Planning Perspectives 109 (1978) (hereinafter cited as *Mortality Rates*); *11 Million Teenagers* (Alan Guttmacher Inst. 1976); Depp Aff. I ¶¶ 11, 13, App. pp. 32-34.

For example, the relative severity and associated level of risk of these medical problems obviously vary from case to case. The availability of medical facilities and resources to provide treatment also varies. Some treatment approaches may require resources which simply are not available in health care facilities to which indigent women have access. In addition, the probable effectiveness of alternative treatment approaches varies. While a range of techniques has been developed to deal with high-risk pregnancies, most of these approaches involve strict regimens, special medication, close supervision and, frequently, hospitalization. A physician must consider whether his patient can adhere to such a program. It may not be possible, for example, for a single parent with small children and no financial resources to rest in bed or to be hospitalized for an extended period of months.

Despite this Court's repeated recognition that "whether 'an abortion is necessary' is a professional judgment that . . . may be exercised in the light of all factors . . . relevant to the well-being of the patient," *Doe* v. *Bolton*, *supra*, 410 U.S. at 192; *Beal* v. *Doe*, *supra*, 432 U.S. at 441-42 n.3, the *amicus* brief filed by certain physicians in support of appellants appears to take the position that an abortion is never medically necessary because there are always alternative medical treatments that are equally effective. This position not only is at odds with this Court's previous statements as to the scope of relevant factors which a physician may weigh in deciding whether an abortion is medically necessary but, as we show below, is also refuted by the medical evidence in the record and in the recognized medical literature.

1. Both pre-existing conditions and complications that arise during pregnancy may pose excessively high risks.

There are numerous pre-existing conditions and complications of pregnancy which pose higher than normal risks to health and life and which will thus alert the physician to the possibility that an abortion may be medically necessary.[6] The following discussion presents a few examples.[7]

Cardiac Diseases and Disorders. While modern medical techniques for the surgical and medical treatment of cardiac disease make it possible for most pregnant women with cardiac disease to survive pregnancy, such women are still at great risk. Perhaps as many as 3.7 percent of all pregnant women have diagnosed cardiac disease.[8]

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[6] The text, *Medical Complications During Pregnancy* (Burrow & Ferris eds. 1975), discusses, in addition to those outlined herein, some 20 major types of complications of pregnancy, including thyroid disease, adrenal and pituitary disorders, gastrointestinal diseases, liver diseases, bacterial and viral infections, pulmonary disease, and neurological complications. *See also* Pernoll, *High-Risk Pregnancy*, in Current Obstetric & Gynecologic Diagnosis & Treatment 560, 562 (Benson ed. 1978).

[7] The *amicus* brief submitted by certain physicians in support of appellants discusses many of these examples. In each instance, they indicate treatments which can reduce the risks posed by the condition and conclude that an abortion is "not appropriate," "not indicated," or "not necessary." We recognize the existence of these forms of treatment and their potential for preventing death or severe health consequences in some cases. These treatments are not, however, effective in all cases or even available or feasible in all cases. As we point out in the text, moreover, the fact is that, despite the existence of sophisticated medical techniques, women still die during pregnancy because of cardiac disease, hypertension, and other conditions and complications discussed *infra*. The *amici* physicians who support appellants simply ignore this fact.

[8] Kahler, *Cardiac Disease*, in Medical Complications During Pregnancy 105 (Burrow & Ferris eds. 1975).

While the mortality rate among such women has declined steadily in the past twenty-five years (in part because of the increased availability of abortions), heart disease remains a significant cause of maternal mortality, accounting for up to 10 percent of all maternal deaths.[9] One study of maternal mortality in Texas found that heart disease caused 4.2 percent of deaths directly related to pregnancy and 17.9 percent of deaths indirectly related to pregnancy.[10]

Heart disease takes many forms, including rheumatic heart disease, congenital heart disease and primary pulmonary hypertension. These diseases have the common effect of reducing the patient's functional cardiac capacity. Since pregnancy increases the demands placed on a woman's cardiovascular system, carrying a pregnancy to term will result in significantly increased risk to a woman with cardiac disease.[11]

A woman whose cardiac capacity is so impaired that she must significantly limit her physical activity is at particularly high risk during pregnancy. Such a woman may be able to carry her pregnancy to term, but only if she is hospitalized for the duration of the pregnancy under strict bed rest, strict diet and administration of digitalis.[12] If such a woman does not respond to such a regimen or cannot be hospitalized for the duration, "car-

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[9] The Merck Manual 518 (13th ed. 1977).

[10] Gibbs & Locke, *Maternal Deaths in Texas 1969-1973*, 126 Am. J. of Obstet. Gynecol. 687 (1976); Messer, *Medical Indications for Pregnancy Interruption*, in Pregnancy Termination: Procedures, Safety and New Developments 305 (Zatuchni, Sciarra & Steidel eds. 1979) (hereinafter cited as *Medical Indications for Pregnancy Interruption*).

[11] Kahler, *Cardiac Disease*, *supra* note 8, at 129.

[12] Pritchard & MacDonald, Williams Obstetrics 612-13 (15th ed. 1976).

diac disease is an urgent indication for therapeutic abortion." [13]

Cancer. Mitchell and Capizzi succinctly summarize the risks of cancer during pregnancy:

> "[O]f all the medical illnesses complicating pregnancy, few are more ominous than cancer. Cancer threatens the life and well-being of the mother, and its required therapy may be hazardous to the fetus." [14]

The existence of cancer may contribute to increased complications during pregnancy, particularly anemia.[15] In addition, while pregnancy does not generally affect the course of cancer, necessary treatment for the cancer may have to be suspended because of the risks to the fetus. For example, "chemotherapy causes considerable risks of teratogenesis and carcinogenesis, if it does not cause [spontaneous] abortion, and generally should be avoided. . . ." [16] An abortion may be medically necessary if therapy cannot be delayed until the pregnancy is brought to term.[17]

Sickle Cell Disease. Sickle cell disease involves the formation of abnormal blood cells which interfere with normal circulation.[18] Whenever oxygen demand increases

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[13] *Id.*; *see also* Kahler, *Cardiac Disease, supra* note 8, at 129-30. The brief of certain *amici* physicians, which asserts that "abortion is not the appropriate treatment for the pregnant patient with cardiac disease," simply does not reflect the weight of medical opinion. Brief at 8.

[14] Mitchell & Capizzi, *Neoplastic Diseases*, in Medical Complications During Pregnancy 738 (Burrow & Ferris eds. 1975).

[15] *Id.* at 740.

[16] *Id.* at 770.

[17] *Id.* at 743.

[18] Sickle cell disorders, which almost exclusively affect blacks, are disorders in the amino acid sequences of hemoglobin molecular structures. The Merck Manual 277 (13th ed. 1977).

in the body (as it does during pregnancy), abnormal or sickle cells develop which cannot flow through capillaries. They thus block the normal flow and result in oxygen starvation, causing extremely painful crises at blockage points. These localized crises can occur anywhere in the body and can affect the functions of the kidneys, lungs, heart and other organs.[19]

While maternal mortality in pregnant women with sickle cell disease is relatively low in the United States, one affiant indicated that a pregnant woman with sickle cell disease has a 25 percent chance of experiencing a crisis and dying as a result of pregnancy.[20] In addition, "maternal morbidity is severe and the frequency of complications is high." [21] These complications include increased anemia, infections, pulmonary complications, hypertension and congestive heart failure. In many instances the maternal risk is considered to be too great, and therapeutic abortions are recommended.[22]

Hypertensive Disorders of Pregnancy. Hypertension (high blood pressure) is one of the most common complications of pregnancy and arises in one of two forms. Some women suffer from pre-existing hypertension and experience magnified symptoms during pregnancy. Other women, who have normal blood pressures before pregnancy, develop hypertension of pregnancy, or preeclampsia, which usually appears after the 20th week of gestation and is associated with proteinurea (excessive protein

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[19] Levin & Algazy, *Hematologic Disorders*, in Medical Complications During Pregnancy 689, 703-04 (Burrow & Ferris eds. 1975).

[20] Zbaraz Aff. ¶ 6(e), App. p. 128.

[21] *Id.*

[22] Levin & Algazy, *Hematologic Disorders, supra* note 19, at 706-07; *see also* Horger & Facog, *Sickle Cell & Sickle Cell-Hemoglobin C Disease During Pregnancy*, 39 Obstetrics & Gynecology 873, 878 (1972).

in urine) and edema (excessive fluid retention).[23] Preeclampsia affects between 5 and 7 percent of all pregnant women; but it affects 30 percent of all indigent women and 24 percent of women with first pregnancies.[24] About 1 out of every 200 women with preeclampsia will experience convulsions, a severe form of the condition referred to as eclampsia.[25]

The treatment of preeclampsia requires extended bed rest, sedation and salt restriction.[26] While some physicians may attempt to treat preeclamptic patients on an outpatient basis, it is usually necessary to hospitalize the patient for a period of weeks.[27]

Contrary to the assertion made by certain *amici* physicians that abortion is never medically indicated for preeclampsia (Brief at 10), there are circumstances in which an abortion is recognized to be medically necessary. As one medical authority states, "pregnancy should be terminated [because of preeclampsia] either when the patient has been given the opportunity to demonstrate maximal response to therapy, or when the physician is

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[23] Jones, *Hypertensive Disorders of Pregnancy*, 8 JOGN Nursing 92-93 (1979) (hereinafter cited as *Hypertensive Disorders*). Preeclampsia is frequently referred to as toxemia.

[24] *Id.*

[25] The Merck Manual 953 (13th ed. 1977). In addition to its immediate effects on a woman's health, preeclampsia may result in significant, negative health consequences to the woman in later life. Some studies indicate, for example, that preeclampsia may be correlated with the subsequent development of hypertension outside of pregnancy and that eclamptic women are more likely to become diabetic. Ferris, *Toxemia and Hypertension*, in Medical Complications During Pregnancy 53, 87 (Burrow & Ferris eds. 1975).

[26] Ferris, *Toxemia and Hypertension*, *supra* note 25, at 81; *Hypertensive Disorders*, *supra* note 23, at 94.

[27] Speroff, *Toxemia of Pregnancy*, 32 Am. J. of Cardiology 582, 590 (1973).

convinced that the patient will fail to respond to treatment." [28]

Renal Disease. Impaired renal or kidney function due to various forms of renal disease poses significant risks during pregnancy, particularly in combination with hypertension or preeclampsia. "Acute renal failure is one of the most serious complications of pregnancy" and often develops late in pregnancy in association with preeclampsia.[29] If renal function and hypertension worsen early in pregnancy, an abortion becomes medically necessary "since there is little likelihood of a successful pregnancy, and renal function may be permanently impaired." [30]

Diabetes Mellitus. Diabetes mellitus [31] is associated with an increase in the incidence of complications in pregnancy, particularly hypertension, impaired renal function, and heart disease. When multiple complications appear, the risk to the woman's health is compounded. Diabetes is also more likely to result in complications if the woman's condition has not yet stabilized under treatment. A woman diagnosed as a diabetic within a year prior to conception is unlikely to have a stabilized condition and is thus at greater risk.[32]

While maternal mortality is not significantly greater among diabetics than among nondiabetics, pregnancy may

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[28] *Id.* at 589.

[29] Ferris, *Renal Disease*, in Medical Complications During Pregnancy 1, 34 (Burrow & Ferris eds. 1975).

[30] *Id.* at 32; *see also* Kreutner & Hollingsworth, Adolescent Obstetrics & Gynecology 192-93 (1978); *Medical Indications for Pregnancy Interruption*, *supra* note 10, at 307.

[31] Diabetes mellitus is a metabolic disease caused by insulin deficiency resulting in increased protein and lipid utilization and decreased carbohydrate utilization.

[32] Graber, Christman, Rawlings & Boehm, Diabetes and Pregnancy 9 (1973).

cause long-term diabetic complications, "may exaggerate the metabolic defect in diabetes," and may cause increased damage to blood vessels.[33] Many women with preexisting retinopathy, a degeneration of the retina which can result from diabetes, have suffered a progression of retinopathy after pregnancy.[34] Similarly, many women with nephropathy, kidney degeneration often caused by diabetes, likewise suffer a progression of this disease as a result of pregnancy.[35] These risks have led one writer to conclude that "in patients with proliferative retinopathy or nephropathy . . ., interruption of pregnancy and sterilization should be the recommended course of action . . . ." [36] Another authority states:

> "If diabetes has been present for more than 20 years, if she has advanced diabetic vascular changes such as retinopathy and/or kidney disease, or if she is over the age of 35, the possibility of complications and an unfavorable outcome of pregnancy are increased to such a degree that the [pregnant] woman should seriously consider . . . a therapeutic abortion in the first trimester of pregnancy." [37]

Venous Disease. Venous thrombosis, pulmonary embolism and varicose veins are all conditions which can cause serious complications during pregnancy.[38] One study found that the risk of blood clotting is approximately five times greater in pregnant women than in

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[33] Felig, *Diabetes Mellitus*, in Medical Complications During Pregnancy 170, 191 (Burrow & Ferris eds. 1975).

[34] *Id.*

[35] *Id.*

[36] *Id.*

[37] Graber *et al.*, Diabetes and Pregnancy, *supra* note 32, at 11.

[38] A thrombosis is a blood clot which is attached to a vessel wall; an embolism is a blood clot which has broken free and migrates through the veins.

nonpregnant control subjects.[39] Women who have used birth control pills are at even greater risk.[40]

The risks associated with clotting continue throughout pregnancy. Generally, anticoagulant therapy is indicated and appears to reduce the mortality rate significantly, but hemorrhaging and possible risks to the fetus may require termination of such therapy,[41] and an abortion may become medically necessary.[42]

Psychiatric Factors. Many women suffer from mental illness which may be exacerbated by a full term pregnancy. A woman who suffers from mental illness and seeks to terminate her pregnancy, moreover, may suffer significant consequences if denied an abortion. One medical expert testified that if a woman suffering from mental illness is "forced to carry a pregnancy to term [she] may become severely depressed or psychotic, may suffer impairment or paralysis of functioning and may engage in . . . self-destructive behavior . . . ." [43]

A physician may treat a pregnant woman who suffers from mental illness by placing her in an institution under close supervision, but such treatment risks additional decline in her condition.[44] Thus, in many instances a psychiatrist may determine that an abortion is medically necessary to protect his patient from severely adverse mental health consequences.[45]

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[39] Hume, *Vascular Disease*, in Medical Complications During Pregnancy 150, 155 (Burrow & Ferris eds. 1975).

[40] Pritchard & MacDonald, Williams Obstetrics 845 (15th ed. 1976).

[41] *Id.* at 161.

[42] Zbaraz Aff. ¶ 7(d), App. pp. 127-28.

[43] Barglow Aff. ¶ 4, App. p. 114; *see also* McRae v. Califano, No. 76-Civ-1804, slip op. at 116-124 (E.D.N.Y. Jan. 15, 1980).

[44] Barglow Aff. ¶ 9, App. p. 117.

[45] *Id.* at ¶ 6, App. pp. 115-16.

2. Teenage pregnancy poses particularly serious health problems.

The physical risks of teenage pregnancy are significant. Teenagers between 15 and 19 years of age are 13 percent more likely than women in their twenties to develop fatal complications; girls under 15 are 60 percent more likely to suffer fatal complications.[46] The incidence of nonfatal complications is also greater among teenagers. The incidence of preeclampsia among teenagers, for example, is 1.3 times as great as the incidence among women in their twenties and is particularly hazardous because of the teenagers' physical immaturity.[47] Young teenagers also experience greater rates of hemorrhage and spontaneous abortion, two of the leading causes of maternal mortality.[48]

Consistent and thorough prenatal care can reduce the likelihood of adverse physical consequences from teenage pregnancy. Contrary to the assertion made by certain *amici* physicians (Brief at 4), however, even the most comprehensive prenatal care does not reduce the risks to the levels experienced by older women.[49] Furthermore, comprehensive prenatal care requires the cooperation of the patient. Many teenagers have a difficult time recognizing the importance of good nutrition and

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[46] *11 Million Teenagers, supra* note 5, at 23.

[47] *Id.*

[48] *Id.*

[49] DHEW, *Adolescent Pregnancy* (August 4, 1977) (decision memorandum); Office of Child Health Affairs, DHEW, *Teenage Pregnancy* 9-10 (December, 1976). The latter report summarizes certain studies on this subject as follows:

> "These studies are consistent in indicating, but by no means proving, that very young women as a group are biologically too immature for effective childbearing. Prenatal care, no matter how comprehensive, appears unable to ensure pregnancy outcomes similar to those sustained by older women." *Id.* at 10.

rest and are less likely than adults to be able to cooperate in a careful program of prenatal care.[50]

Pregnancy also interrupts a young teenager's physical and emotional development, with potentially long-lasting or permanent consequences. This problem is particularly prevalent among young teenagers who carry their pregnancies to term within two years after the onset of menses.[51] Although the emotional and psychological consequences of teenage pregnancy are more difficult to quantify than the physical risks, they are of equal or greater long-run importance.

The severity of the stress an unwanted pregnancy may produce in a teenager is apparent from suicide and illegal abortion statistics. For teenage girls, actual or suspected pregnancy is a major cause of suicide attempts.[52] Prior to the legalization of abortion in 1970, the principal cause of death among pregnant adolescents in New York was illegal abortion.[53] A teenager is more likely than a mature woman to resort to illegal abortion or self-abortion because she is more likely to be desperate, to have limited access to the health care system, to lack knowledge of basic medical facts and anatomy, to misjudge or ignore risks, and to use crude and dangerous methods.[54]

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[50] *11 Million Teenagers, supra* note 5, at 38.

[51] *Teenage Pregnancy, supra* note 49, at 5.

[52] Teicher, *A Solution to the Chronic Problem of Living: Adolescent Attempted Suicide*, in Current Issues in Adolescent Psychiatry 124 (Brunner-Mazel ed. 1973).

[53] McRae v. Califano, No. 76-Civ-1804, Tr. at 1347 (E.D.N.Y. 1976).

[54] *Id.* Not only does illegal abortion carry the risk of death and sterility, but it also generates greater guilt and anxiety than are experienced with legal abortion. *See* Nadelson, *Abortion Counselling: Focus on Adolescent Pregnancy*, 54 Pediatrics 765, 767 (1978).

All of the increased risks faced by pregnant teenagers generally are even further magnified for the young teenager, *i.e.*, the girl under the age of 15.[55] Fertility is increasing, not declining, in this age group.[56] The adverse effects are multiplied, moreover, when second pregnancies occur while the mothers are still under 20, as they frequently do when the first pregnancy occurs in the early teens.[57]

B. The Illinois Statute Will Make Publicly Funded Abortions Unavailable To A Significant Number Of Indigent Women For Whom Abortions Are Found To Be Medically Necessary.

The District Court found that most health problems associated with pregnancy would not be covered by the Illinois statute, which provides funding only for abortions certified to be "necessary for the preservation of the life of the woman," and it further found that "those that would be covered would often not be apparent until the later stages of pregnancy, when an abortion is more dangerous to the mother." 469 F. Supp. at 1220. In support of these findings, the court correctly pointed out that:

> "The affidavits submitted by plaintiffs give many examples of medical conditions which would not be covered by the new Illinois standards, but which could pose a great threat to the safety of the mother." *Id.*, n.12.

The District Court accordingly concluded that "the Illinois statute as modified will deny needed medical aid to indigent mothers . . . ." *Id.* at 1220. Of course, this finding is hardly surprising in view of the medical testimony as to the nature of the medical conditions which

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[55] *Teenage Pregnancy, supra* note 49, at 1, 4-5.

[56] *Id.* at 1; *11 Million Teenagers, supra* note 5, at 12.

[57] *Teenage Pregnancy, supra* note 49, at 6.

may be adversely affected by pregnancy and the complications which may arise. *See* subpart A, *supra.*

That testimony demonstrates that there are relatively few cases in which a physician will be able to certify at an early stage of pregnancy that an abortion is "necessary for the preservation of the life of the woman." Rather, most cases present an array of possible outcomes, of varying degrees of probability, which might ensue from an observed condition or combination of conditions. A physician cannot measure these probabilities with any degree of precision; the various factors he must consider are inherently uncertain.

Nor will any two physicians identify and assess risks in identical fashion. Physicians vary in their emphasis on certain factors, in their experience with the diagnosis and treatment of certain diseases, and in their threshold of intervention.[58]

It is clear, however, that a woman's health may be placed in serious jeopardy if her physician is forced to delay his decision until probabilities approach certainties or until unanimity among his colleagues can be achieved. Indeed, such delay may cause her health to deteriorate to a crisis condition.[59] Every week an abortion is delayed,

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[58] *See* Depp Aff. II ¶ 11, App. pp. 106-07. This Court has repeatedly recognized that medical judgments are based on assessments of numerous factors that cannot be evaluated with precision and that judgments thus are likely to vary from physician to physician. *See, e.g.*, Colautti v. Franklin, *supra*, 439 U.S. at 395-96.

[59] In a similar context, this Court recognized the critical importance of taking medical action before a patient's condition requires emergency treatment. In ruling on a state durational residency requirement applicable to the provision of nonemergency medical care to indigents, the Court stressed that:

> "The State could not deny [an indigent] care just because, although gasping for breath, he was not in immediate danger of stopping breathing altogether. To allow a serious illness to go untreated until it requires emergency hospitalization is

moreover, the procedure itself involves greater risks of complications.[60]

There is, of course, no way of knowing how many medically necessary abortions will be performed if the Illinois statute is upheld. The District Court pointed out that "affidavits submitted by respected members of the medical profession . . . suggest that the percentage of abortions any physician would deem 'medically necessary' may be as low as one fifth of the representative cases in which a pregnant woman desires an abortion." 469 F. Supp. at 1221.[61] Whatever the percentage, however, it is clear that the Illinois statute would deny funding for a substantial number of abortions deemed to be medically necessary by the physicians of the indigent women in question.

C. The Effect Of The Illinois Statute Will Be To Increase Morbidity And Mortality Among Indigent Pregnant Women.

Not surprisingly, no studies have been published which directly compare the mortality or morbidity rates of women having specific medical diseases who carried their pregnancies to term with the rates of other women having the same diseases who terminated their pregnancies. Studies of general death-to-case ratios are available,[62] however, and clearly support the finding of the District

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to subject the sufferer to the danger of a substantial and irrevocable deterioration in his health . . . . The denial of medical care is all the more cruel in this context, falling as it does on indigents who are often without the means to obtain alternative treatment." Memorial Hospital v. Maricopa County, 415 U.S. 250, 260-61 (1974) (footnote omitted).

[60] *Mortality Rates, supra* note 5, at 111.

[61] One of the same affiants estimated that the percentage might be as high as 50%. *See* Depp Aff. II ¶ 11, App. pp. 106-07.

[62] *See generally Mortality Rates, supra* note 5.

Court that the effect of the Illinois statute "will be to increase substantially maternal morbidity and mortality among indigent pregnant women." 469 F. Supp. at 1220.

One such study shows, for example, that if a woman carries her pregnancy to term, her risk of death is more than 24 times greater than her risk of death from an abortion performed during the first eight weeks of pregnancy.[63] If, after some delay, she obtains an abortion (either because she finds a private source of funding or her physician eventually determines that her case can be certified for reimbursement), her risk of death increases simply because of the delay. The mortality rate for abortions increases over thirty-fold from the eighth week to the sixteenth week of gestation.[64] If she tries to self-induce an abortion or obtains an illegal abortion, her risk of death is at least 100 times her risk of death from a legal first trimester abortion.[65] Comparable morbidity ratios would be even more extreme, moreover, for the pregnancy morbidity rate is generally four to ten percent higher than the pregnancy mortality rate.[66]

These risks must, by definition, be even greater among those women for whom abortions have been found to be medically necessary but who cannot obtain them. One study included in the record estimates, for example, that the increase in mortality resulting from adoption of the Hyde Amendment (which imposes restrictions on the funding of abortions that are somewhat less severe than the Illinois statute) will be approximately seventy-seven

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[63] *Id.* at 112.

[64] *Id.* at 111.

[65] Tietze, *The Effect of Legalization of Abortion on Population Growth and Public Health*, 7 Family Planning Perspectives 123 (1975).

[66] Depp Aff. II ¶ 11, App. p. 106.

deaths per year.[67] In *McRae* v. *Califano, supra*, the district court likewise found, on the basis of an extensive record, that the Hyde Amendment restrictions on funding for abortions would result in significant increased mortality. (Slip op. at 158).

Contrary to the assertion made in the *amicus* brief of the National Right To Life Committee, moreover, there is *no* evidence that the abortion funding restrictions imposed by the Hyde Amendment have not resulted in an increase in mortality or morbidity among Medicaid recipients. (National Right to Life Brief at 17). Indeed, the assertion in the Committee's brief to that effect is based on an outright misrepresentation as to the findings of a recent report by the Center for Disease Control.[68] That report deals only with the impact of the Hyde Amendment on the incidence of *abortion-related complications*, which were defined to include only "illness related to either an induced or a spontaneous abortion that caused a woman to come to an acute-care facility," and found no increase in the incidence of those complications. The report did not even consider whether increased morbidity or mortality results from *pregnancy-related complications* when women in medical need of abortions cannot obtain them because they are denied funding.[69]

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[67] Petitti & Cates, *Restricting Medicaid Funds for Abortions: Projections of Excess Mortality For Women of Childbearing Age*, 67 Am. J. of Pub. Health 860, 861 (1977).

[68] *Health Effects of Restricting Federal Funds for Abortion—United States*, 28 Morbidity & Mortality Weekly Report 37 (1979).

[69] In further support of its contention that the health of indigent women denied medically necessary abortions has not been jeopardized by the Hyde Amendment, the Committee states that "one abortion is not equivalent to one birth. . . . [T]wo abortions are needed to avert one birth" and thus asserts that the risks of a full term pregnancy must be compared to the risks of two abortions. National Right to Life Brief at 17. The Committee bases this highly misleading statement on testimony of Dr. Christopher Tietze before a subcommittee of the Senate Judiciary Committee on the use of abortion as a method of reducing population growth. His testimony indicates that if no other contraceptive methods were practiced, the average woman might conceive seven times during her lifetime. Dr. Tietze estimated that to reduce that average from seven to six, each woman would have to have two abortions during her lifetime. *Abortion—Part 2: Hearings before the Subcomm. on Constitutional Amendments of the Senate Comm. on the Judiciary*, 93d Cong., 2d Sess. 52 (1976). Dr. Tietze points out, however, that if every woman used contraceptives of 95 percent effectiveness, less than one abortion per woman would be required to reduce fertility by one. *Id.* Thus, the Committee's contention that the risks of carrying a pregnancy to term must be compared to the risks of having two abortions is not even remotely supported by the only authority it cites for this proposition.

It is clear, then, that the District Court's findings are valid and substantiated by the record and the medical literature. Many indigent women who become pregnant suffer from pre-existing conditions or develop complications during pregnancy which entail high risks. In many instances, the woman's physician, in the exercise of his best professional judgment and after weighing the various treatment alternatives, would conclude that the risks to the woman's health and life cannot be sufficiently reduced by any methods other than an abortion.

Yet Illinois refuses to fund such abortions. As a result, the class of indigent women for whom abortions are medically necessary will suffer substantially increased morbidity and mortality. As we show below, Illinois' failure to fund such medically necessary abortions constitutes a denial of the equal protection of the laws.

II. ILLINOIS' REFUSAL TO FUND MEDICALLY NECESSARY ABORTIONS VIOLATES THE EQUAL PROTECTION CLAUSE.

In *Roe* v. *Wade*, 410 U.S. 113 (1973), and a series of subsequent cases (discussed *infra*), this Court has struck down a variety of state statutes prohibiting or otherwise circumscribing abortion. Appellants rely primarily on only one abortion-related decision of this

Court, *Maher* v. *Roe*, 432 U.S. 464 (1977), in support of their argument that the Illinois denial of funding for medically necessary abortions does not violate the Constitution. Even in that decision, however, the Court began with the premise that a state's provision of medical care to indigents must meet constitutional standards:

> "The Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents. But when a State decides to alleviate some of the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations." *Maher* v. *Roe*, *supra*, 432 U.S. at 469-70 (footnote omitted).

Illinois has decided to alleviate some of the hardships of poverty by providing medical care. It dispenses benefits by funding essentially all medically necessary treatment except medically necessary abortions. Thus, within a class of Medicaid-eligible persons, Illinois has carved out a subclass—pregnant women in medical need of abortions—and denies that subclass the funds its members require if they are to pay for the treatment they need.

This classification violates the Equal Protection Clause of the Fourteenth Amendment. The framework of analysis under that clause was reiterated in *Maher* v. *Roe*:

> " 'We must decide, first, whether [state legislation] operates to the disadvantage of some suspect class or impinges upon a fundamental right explicitly or implicitly protected by the Constitution, thereby requiring strict judicial scrutiny. . . . If not, the [legislative] scheme must still be examined to determine whether it rationally furthers some legitimate, articulated state purpose and therefore does not constitute an invidious discrimination . . . .' " *Id.* at 470, *quoting San Antonio Independent School District* v. *Rodriguez*, 411 U.S. 1, 17 (1973).

We submit, first, that the Illinois statute impinges upon a fundamental right and cannot survive strict scrutiny and, second, that the statute does not even rationally further a legitimate, articulated state interest.

The District Court below, believing that *Maher* foreclosed it from subjecting an abortion funding restriction to strict scrutiny, applied the rational basis test to Illinois' decision to single out medically necessary abortions for exclusion from its Medicaid program. Under reasoning which *amici* fully support, the court found that the statute fails to meet even that very generous standard. We also believe, however, that the facts and interests involved distinguish this case from *Maher* (*see* pp. 37-38 *infra*) in such a way that strict scrutiny is appropriate. Under either line of analysis, the Illinois statute is unconstitutional, and the judgment of the District Court should be affirmed.[70]

A. The Illinois Statute Should Be Subjected To Strict Scrutiny.

Whether a welfare or funding statute impinges upon a fundamental right depends on whether it affects the exercise of constitutionally protected rights and interests, not on whether a constitutional right to the welfare benefits themselves exists. For example, in *Shapiro* v. *Thompson*, 394 U.S. 618, 629-31, 638 (1969), this Court struck down a waiting period requirement in a welfare statute because it touched on the fundamental right of interstate travel. Similarly, in *Dunn* v. *Blumstein*, 405 U.S. 330, 338 (1972), and *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250, 254 (1974), the Court sub-

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[70] Because the District Court thoroughly developed the rational basis analysis and did not apply the strict scrutiny test, we devote greater attention to the strict scrutiny argument. By doing so, we seek only to stress the importance of the interests that we believe justify the application of the strict scrutiny test, and not to suggest that the District Court's rational basis analysis is inadequate.

jected durational residence conditions, related to voting in one case and to medical care in the other, to strict scrutiny because they impinged upon the right to travel. By contrast, in *San Antonio Independent School District* v. *Rodriguez*, *supra*, 411 U.S. at 35, the Court did not strictly scrutinize a school financing scheme because the interest affected—the interest in education—was found not to be fundamental.[71]

In this case, Illinois' decision to withdraw funding of certain abortions impinges upon "the constitutional right of a woman, in consultation with her physician, to choose to terminate her pregnancy." *Bellotti* v. *Baird*, —— U.S. ——, 99 S. Ct. 3035, 3046 (1979) (Powell, J.); *see Roe* v. *Wade*, *supra*, 410 U.S. at 153. This right is unquestionably fundamental. *See, e.g., id.* at 152-53; *San Antonio Independent School District* v. *Rodriguez*, *supra*, 411 U.S. at 34 n.76; *Cleveland Board of Education* v. *LaFleur*, 414 U.S. 632, 640 (1974); *Zablocki* v. *Redhail*, 434 U.S. 374, 386 (1978).

It is true that equal protection analysis is not ended by a determination that a statutory classification touches on a fundamental right; some inquiry into the degree of impact on the right is appropriate. *See, e.g., Memorial Hospital* v. *Maricopa County*, *supra*, 415 U.S. at 256-

[71] *Cf.* Weinberger v. Salfi, 422 U.S. 749 (1975), cited by appellant Miller for the proposition that welfare is not a fundamental right. Miller Brief at 17. Although this proposition may well be true, it is immaterial because a right to welfare is neither asserted nor at issue here. Further, the Court in *Salfi* acknowledged that there are constitutional limitations on the manner in which welfare benefits are dispensed:

> "[A] noncontractual claim to receive funds from the public treasury enjoys no constitutionally protected status, . . . though of course Congress may not invidiously discriminate among such claimants on the basis of a 'bare congressional desire to harm a politically unpopular group,' . . . or on the basis of criteria which bear no rational relation to a legitimate legislative goal." 422 U.S. at 772 (citations omitted).

57; *Maher* v. *Roe*, *supra*, 432 U.S. at 472-74; *cf. Bellotti* v. *Baird*, 428 U.S. 132, 147, 149-50 (1976). To be impermissible, however, the interference with the exercise of the right need not be absolute. Nor must exercise of the right actually be deterred. It is sufficient if the classification penalizes or unduly burdens the exercise of the right. *See Shapiro* v. *Thompson*, *supra*, 394 U.S. at 631, 634; *Dunn* v. *Blumstein*, *supra*, 405 U.S. at 339-41; *Memorial Hospital* v. *Maricopa County*, *supra*, 415 U.S. at 257-58; *Maher* v. *Roe*, *supra*, 432 U.S. at 473; *cf. Sherbert* v. *Verner*, 374 U.S. 398 (1963).[72] A careful examination of the rights and interests undergirding the right to choose an abortion, as delineated in *Roe* v. *Wade*, *supra*, and of the impact of Illinois' denial of funding for medically necessary abortions demonstrates that the

[72] In *Sherbert* v. *Verner*, the Court ruled that a denial of unemployment compensation benefits due to the claimant's refusal to work on Saturday burdened the claimant's free exercise of her religion. Even though the case focused on a First Amendment right, the Court's analysis in that case is like the penalty analysis in equal protection cases and applies with equal force here:

> "We turn first to the question whether the disqualification for benefits imposes any burden on the free exercise of appellant's religion. We think it is clear that it does. In a sense the consequences of such a disqualification to religious principles and practices may be only an indirect result of welfare legislation within the State's general competence to enact; it is true that no criminal sanctions directly compel appellant to work a six-day week. But this is only the beginning, not the end, of our inquiry. For '[i]f the purpose or effect of a law is to impede the observance of one or all religions or is to discriminate invidiously between religions, that law is constitutionally invalid even though the burden may be characterized as being only indirect.' Braunfeld v. Brown, [366 U.S. 599] at 607. Here not only is it apparent that appellant's declared ineligibility for benefits derives solely from the practice of her religion, but the pressure upon her to forego that practice is unmistakable. . . . Governmental imposition of such a choice puts the same kind of burden upon the free exercise of religion as would a fine imposed against appellant for her Saturday worship." 374 U.S. at 403-04 (footnote omitted).

denial of funding unduly burdens the exercise of the right to choose an abortion.

Roe v. *Wade*, its companion decision *Doe* v. *Bolton*, 410 U.S. 179 (1973), and their progeny, in analyzing the woman's fundamental privacy right encompassing the abortion decision, have stressed several interests related to that right and the abortion decision. Among these are the following: the woman's interest in her health; the woman's corollary interest in obtaining her physician's best medical judgment, untainted by nonmedical considerations such as her ability to pay; and the state's interest in the woman's health. *E.g.*, *Roe* v. *Wade*, *supra*, 410 U.S. at 153, 162-64.[73]

The interest in the woman's health has been emphasized in several recent decisions. In *Connecticut* v. *Menillo*, 423 U.S. 9 (1975) (per curiam), the Court upheld the state's efforts to prohibit the performance of abortions by nonphysicians because such a prohibition promoted the health of the women affected. In *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 75-79 (1976), and *Colautti* v. *Franklin*, 439 U.S. 379, 398-400 (1979), the Court struck down state regulations adverse to the health interests of the women affected.[74] *See also Williams* v. *Zbaraz*, 99 S. Ct. 2095, 2098-99 (1979) (Stevens, J.) (denial of stay). The interest of a woman in securing the sound medical judgment of her physician has likewise been a

[73] Of course, *Roe* v. *Wade* also recognized a state interest in potential life. That interest, addressed at pp. 42-43 *infra*, is not discussed here because it is not infringed by the Illinois statute and because this Court has emphasized that it cannot override the interest in the woman's life and health. *See* Roe v. Wade, *supra*, 410 U.S. at 164-65; Colautti v. Franklin, 439 U.S. 379, 400 (1979).

[74] In *Planned Parenthood*, the Court invalidated a prohibition on the use of a method of abortion that was safer for the woman than various alternative methods. In *Colautti*, the Court held that a statute appearing to give fetal existence priority over the health of the woman was unconstitutional.

focus in a number of recent decisions. *See, e.g., Doe* v. *Bolton, supra*, 410 U.S. at 191-92; *Planned Parenthood* v. *Danforth, supra*, 428 U.S. at 63-64; *Colautti* v. *Franklin, supra*, 439 U.S. at 387-88, 393-94.[75]

Illinois does not and cannot argue that, like the state action in *Menillo*, its denial of Medicaid funding for medically necessary abortions promotes the health of women. Instead, like the statutes in *Planned Parenthood* and *Colautti*, the Illinois statute can serve only to interfere substantially with the woman's interest in her health and to thwart rather than advance the state's interest in her health.

By definition, Medicaid-eligible women do not have sufficient income and resources to meet the costs of necessary medical services. The denial of funding leaves these women with few courses of action other than forgoing needed abortions or procuring the additional funds necessary to finance legal abortions.[76] Because an abortion is medically necessary only when it is likely that pregnancy or childbirth will entail excessive risks, forgoing such an abortion necessarily exposes a woman to a significant possibility of health damage or death. Even if

[75] *See* Part I, *supra*, for discussion of the factors that only a physician can evaluate.

[76] Other possible courses of action include obtaining free abortions, attempting self-abortions, and procuring cheap illegal or "back alley" abortions. However, few free abortions are available, and the medical system cannot reasonably be expected to absorb the cost of abortions for all Medicaid-eligible women who need them. *Abortions and the Poor: Private Morality, Public Responsibility* 28 (Alan Guttmacher Inst. 1979). Conclusive evidence on the extent to which the lack of funding is forcing or will force resort to self-abortions and back alley abortions is difficult to gather. Early evidence appeared to indicate that few such abortions were occurring, but more recent data suggest an increase in such abortions. *See* Center for Disease Control, *Health Effects of Restricting Federal Funds for Abortion—United States*, 28 Morbidity & Mortality Weekly Report 37 (1979) and unpublished data available from the CDC, cited in *The Atlanta Constitution*, Feb. 12, 1980, at 3-A, col. 2.

a woman ultimately is able to secure the funds to pay for an abortion,[77] the delay that occurs while she collects the funds itself involves health risks and also magnifies the risks inherent in the abortion procedure.[78]

The woman's interest in her physician's medical judgment is similarly infringed by the Illinois statute. The absence of funding through the channels normally used by the indigent patient and her physician for medically necessary treatment injects a nonmedical factor—money—into the physician's evaluation of the woman's needs. Indeed, the lack of funding may effectively remove from the physician's consideration the one form of treatment that may be the most appropriate means of preserving his patient's health.

Memorial Hospital v. *Maricopa County*, *supra*, establishes that when the exercise of a constitutional right is burdened by the withholding of funding for medical care that is necessary for the preservation of health, such a deprivation impinges upon the exercise sufficiently to invoke strict scrutiny under the Equal Protection Clause. The Court there held that a temporary denial to indigents of nonemergency health care penalized the exercise of the right to travel because it subjected those affected to "the danger of a substantial and irrevocable deterioration of . . . health," though not to an immediate risk of death. 415 U.S. at 259-61. Further, as Justice Blackmun noted in *Singleton* v. *Wulff*, 428 U.S. 106, 118-19 n.7 (1976): "For a doctor who cannot afford to work

[77] The woman may resort to obtaining the necessary funds for the abortion out of general public assistance, her only other ready source of money, and thereby deprive herself or her family of other basic necessities.

[78] As was fully discussed in Part I above, for all of these reasons the District Court properly found that the denial of funding for medically necessary abortions will substantially increase maternal mortality and morbidity among those affected. Zbaraz v. Quern, 469 F. Supp. 1212, 1220 (N.D. Ill. 1979).

for nothing, and a woman who cannot afford to pay him, the State's refusal to fund an abortion is as effective an 'interdiction' of it as would ever be necessary." [79]

In short, when measured against prior decisions of this Court, Illinois' denial of funding for medically necessary abortions clearly penalizes and nearly interdicts the exercise of a fundamental right, and, accordingly, should be subjected to strict scrutiny under the Equal Protection Clause.[80] To avoid such scrutiny, the appellants rely heavily on *Dandridge* v. *Williams*, 397 U.S. 471 (1970), and on *Maher* v. *Roe*, *supra*. *See*, *e.g.*, Miller Brief at 76, 79; Williams Brief at 37, 43, 64-65, 67-69; United States Brief at 51-53. In *Maher* the Court did hold that a statute precluding Medicaid funding of certain abortions did not have to withstand strict scrutiny. *Maher* v. *Roe*, *supra*, 432 U.S. at 474, 477. There is a critical distinction between this case and *Maher*, however, which renders *Maher's* holding inapplicable here.

Maher addressed demands for funding of nontherapeutic abortions. *Id.* at 466-67. Therefore, the health interests that are central to this case and that are in-

[79] *See also* Williams v. Zbaraz, *supra*, 99 S. Ct. at 2098, 2099 (recognizing that, without funding, many if not most indigent women for whom abortions are medically necessary will not be able to have them, and their constitutional right to choose abortion will be meaningless).

[80] As the District Court below indicated, the equal protection analysis subsumes due process analysis. Zbaraz v. Quern, *supra*, 469 F. Supp. at 1216 n.5. Because the funding denial unduly burdens and nearly interdicts the exercise of a fundamental right, it could appropriately be analyzed under the Due Process Clause of the Fourteenth Amendment. *See* Maher v. Roe, *supra*, 432 U.S. at 484-89 (Brennan, Marshall, and Blackmun, JJ., dissenting); *cf.* Zablocki v. Redhail, *supra*, 434 U.S. at 391-96 (Stewart, J., concurring). The funding denial clearly disturbs the balance of interests struck in *Roe* v. *Wade*, by establishing the state's preference for fetal existence over the health of the woman, even during the first two trimesters of pregnancy.

terests of the state as well as of the woman [81] simply were not implicated in *Maher*. Moreover, in seeking funding for nontherapeutic abortions, the plaintiffs in *Maher* were, in effect, seeking more favorable treatment than other Medicaid-eligible persons received, for the Medicaid program generally covers only medically necessary services, not nontherapeutic ones. *See id.* Thus, unlike the present case, *Maher* did not involve discrimination among medically necessary treatments, and the denial of funding there did not expose the pregnant plaintiffs to substantial deleterious effects on their health.[82]

Dandridge v. *Williams*, *supra*, likewise is inapposite, for two reasons. First, as the Court in *Dandridge* itself noted, the regulation in *Dandridge*, which allocated welfare funds among eligible families, did not affect freedoms guaranteed by the Bill of Rights. *Dandridge* v. *Williams*, *supra*, 397 U.S. at 484; *see Department of Agriculture* v. *Moreno*, 413 U.S. 528, 544 (1973) (Douglas, J., concurring). As the Court reasoned in *Weber* v. *Aetna Casualty & Surety Co.*, 406 U.S. 164, 172 (1972): "Though the latitude given state economic and social regulation is necessarily broad, when state statutory classifications approach sensitive and fundamental personal rights, this Court exercises a stricter scrutiny." Unlike the classification in *Dandridge*, the Illinois classification in denying funding for medically necessary abortions imposes a substantial impediment to the exercise of such sensitive and fundamental personal rights.

[81] Roe v. Wade, *supra*, 410 U.S. at 154, 159, 162-63.

[82] This distinction also undercuts appellants' reliance on an observation appearing in a footnote in the *Maher* opinion: "*Shapiro* and *Maricopa County* did not hold that States would penalize the right to travel interstate by refusing to pay the bus fares of the indigent travelers." Maher v. Roe, *supra*, 432 U.S. at 474-75 n.8. Appellants seize upon this statement as support for their argument that Illinois does not penalize the exercise of the right to seek an abortion by refusing to pay for it. *See* Miller Brief at 76; Williams Brief at 40, 68. The Court's observation in *Maher*, however, suggests only that states have no affirmative obligation, in the absence of other factors, to pay for the means to effectuate certain rights; it does *not* mean that states that generally provide payment for medically necessary services can choose to exclude payment for one such service, when that exclusion interferes with the effectuation of a fundamental right.

Second, the premise of *Dandridge* was that, because the state's welfare funds were finite, an increase in the benefits for those who claimed that they were treated unfairly would have necessitated a decrease in the benefits of others. *Dandridge* v. *Williams*, *supra*, 397 U.S. at 479; *see Jimenez* v. *Weinberger*, 417 U.S. 628, 633 (1974). That is not the situation in the case now before the Court. Because abortions are significantly less expensive than the medical care associated with full-term pregnancies and childbirth,[83] the allocation of public funds for abortions will increase the amount of funds available for other purposes.[84] *Dandridge* thus is inapplicable on this ground as well.

In sum, the discrimination imposed by the Illinois statute between indigent women in medical need of abortions and indigent persons in need of other medical services impinges upon the fundamental right to seek an abortion and should be subjected to strict scrutiny.

B. The Illinois Statute Does Not Further A Compelling State Interest.

A statute subjected to strict scrutiny under the Equal Protection Clause must further a compelling state inter-

[83] Indeed, as Justice Stevens noted in denying a stay of the District Court's order in this case: "[I]t is less expensive for the State to pay the *entire cost* of abortion than it is for it to pay only its *share of the costs* associated with a full-term pregnancy." Williams v. Zbaraz, *supra*, 99 S. Ct. at 2098 (emphasis added).

[84] *Cf.* Jimenez v. Weinberger, *supra*, 417 U.S. at 633 (*Dandridge* distinguished; in *Jimenez*, there was no showing that correction of the invalid classification would significantly impair the fund or necessitate a reduction in the scope of persons benefited).

est if it is to stand. *E.g.*, *Memorial Hospital* v. *Maricopa County*, *supra*, 415 U.S. at 254, 262. As the District Court below correctly concluded, and as is more fully discussed in Part II.C. below, the Illinois denial of funding for medically necessary abortions does not even rationally further a legitimate state interest. The denial *a fortiori* does not further a compelling state interest.

C. The Illinois Statute Does Not Rationally Further A Legitimate State Interest.

Even if a statutory classification neither impinges upon a fundamental right nor discriminates against a suspect class, it still must be rationally related to a legitimate governmental purpose. *Maher* v. *Roe*, *supra*, 432 U.S. at 478. As the District Court's analysis makes clear, however, the state interests asserted below do not support the Illinois funding discrimination between medically necessary abortions and other medically necessary services.[85] Moreover, the record shows that whatever

[85] On this appeal, appellants raise several justifications not offered below. These justifications, untimely raised, either are not legitimate state interests or are not furthered by the statute. For example, appellants postulate an interest in avoiding spending public funds, raised by taxes, to support an activity that many taxpayers find morally repugnant. *E.g.*, Miller Brief at 80; Williams Brief at 57, 61-62; United States Brief at 55. This interest is not legitimate for purposes of equal protection analysis. As the Court stated in *Department of Agriculture* v. *Moreno*, *supra*, 413 U.S. at 534: "[I]f the constitutional conception of 'equal protection of the laws' means anything, it must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot constitute a legitimate governmental interest." [Emphasis the Court's.] *See also* Weinberger v. Salfi, *supra*, 422 U.S. at 772 (quoting *Moreno*); Memorial Hospital v. Maricopa County, *supra*, 415 U.S. at 266 (state may not maintain political acceptability of programs by excluding an unpopular class from benefits); *cf.* Examining Board of Engineers v. Flores de Otero, 426 U.S. 572, 605 (1976) ("[asserted] justification amounts to little more than an assertion that discrimination may be justified by a desire to discriminate"). Taxpayer wishes cannot justify the infringement of others' rights;

permissible interests are now asserted to justify singling out medically necessary abortions for exclusion from the Medicaid program were far from the minds of the Illinois legislators who enacted the statute; the real purposes of the statute are impermissible ones.

The District Court properly disposed of the assertion of a state interest in limiting public welfare expenditures and allocating scarce funds. The record clearly establishes that an abortion costs significantly less than a normal full-term pregnancy and delivery. Therefore, it obviously costs less than an *abnormal* pregnancy and birth requiring more than normal medical care. *Zbaraz* v. *Quern*, *supra*, 469 F. Supp. at 1218; *see Williams* v. *Zbaraz*, *supra*, 99 S. Ct. at 2098. Additionally, as a result of the Illinois statute, the state may incur costs of placing children their mothers cannot care for, costs of care for abnormal children, and increased welfare costs for children the mothers cannot support. Any assertion of a fiscal interest in the limitation of abortion funding is frivolous.

The appellants have emphasized a second interest, that in encouraging childbirth, because this Court in *Maher* recognized that the encouragement of *normal* childbirth is a legitimate state interest. Miller Brief at 78-80;

the Bill of Rights and the Fourteenth Amendment were designed in part precisely to shield certain rights and liberties of minorities from encroachment by the majority or a more powerful minority. *Cf.* Glasson v. City of Louisville, 518 F.2d 899, 905-06 (6th Cir.), *cert. denied*, 423 U.S. 930 (1975).

The intervening appellants also suggest an interest in preventing fraud. Williams Brief at 76-83. This Court provided a sufficient answer to this argument in *Roe* v. *Wade*, *supra*, 410 U.S. at 166: "If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available." Guarding against fraud by blocking access to abortions by indigents who need them is irrational. *Cf.* Shapiro v. Thompson, *supra*, 394 U.S. at 636; Examining Board of Engineers v. Flores de Otero, *supra*, 426 U.S. at 606.

Williams Brief at 48, 56; United States Brief at 57-64; *see Maher* v. *Roe*, *supra*, 432 U.S. at 477. The District Court also correctly found that this interest, the boundaries of which are defined by *Roe* v. *Wade* and *Maher* v. *Roe*, does not support the Illinois statute.

Roe v. *Wade* emphasized that the state has two interests related to pregnancy which may justify regulations affecting abortion. One is in the health of the woman and the other is in the potential life of the fetus. Both of the state's interests exist throughout a pregnancy though they do not become compelling until certain points during the pregnancy. *Roe* v. *Wade*, *supra*, 410 U.S. at 162-63.[86] *Maher* recognized that the state could take certain actions to implement its interest in potential life, even during the first two trimesters, where the health of the woman, or the state's interest in that health, was not at risk. *Maher* did not, however, accelerate the time at which the state's interest in potential life becomes compelling or authorize a state to give fetal life priority over the life or health of the woman. *See Colautti* v. *Franklin*, *supra*, 439 U.S. at 400.

On the contrary, *Roe* v. *Wade*, *supra*, 410 U.S. at 163-64, made it clear that the state may not proscribe an abortion even after viability "when it [the abortion] is necessary to preserve the life *or health* of the mother." (Emphasis added.) As Justice Stevens pointed out in denying appellants' applications for a stay in this case:

> "*Roe* v. *Wade*, 410 U.S. 113, . . . itself establishes that the State's interest in potential life is never so great that it can outweigh the woman's interest in her health . . . . Moreover, the State clearly has an interest in preserving and protecting the life and health of the mother, as well as in promoting child-

[86] The state's interest in the woman's health becomes compelling first, approximately at the end of the first trimester. The interest in potential life becomes compelling at the point of viability. *Id.*

> birth. In this case, where we deal only with 'medically necessary' abortions, the weight to be accorded to the State's interest in childbirth must necessarily be diminished by its acknowledged interest in the health of the mother." *Williams* v. *Zbaraz*, *supra*, 99 S. Ct. at 2098.

Furthermore, it must be remembered that the state interest in promoting childbirth which this Court acknowledged in *Maher* was repeatedly described as an interest in promoting *normal* childbirth. *Maher* v. *Roe*, *supra*, 432 U.S. at 477, 479; *see also Beal* v. *Doe*, 432 U.S. 438, 446 (1977). Yet the Illinois statute does not further this legitimate interest at all.

Childbirth cannot be "normal childbirth," we submit, when it results from the inability to obtain a medically necessary abortion. It does not "encourage normal childbirth" to deny a poor woman the funds to terminate a pregnancy where that pregnancy may cause or exacerbate a condition threatening her health or life. It does not "encourage normal childbirth" to deny a poor woman funds to terminate a pregnancy likely to end, at a later date, in surgical intervention that could pose a threat to her life. It does not "encourage normal childbirth" to force a woman with serious psychological problems to undergo the extreme stress of an unwanted pregnancy, which might foreclose the possibility that she will conquer her illness.[87]

[87] Moreover, even if the Illinois statute could be deemed to further this or another permissible state interest asserted by the parties, it does not *rationally* further such an interest. It is not rational for a state to achieve even a legitimate state purpose by deliberately inflicting harm on certain citizens. *See* Carey v. Population Services International, 431 U.S. 678, 715-16 (1977) (Stevens, J., concurring). This is especially true in this case, where the state has an affirmative interest, recognized by this Court in *Roe* v. *Wade*, in the maternal health that is harmed by the statute.

In short, none of the asserted state interests justifies the Illinois statute. Furthermore, a reading of the legislative history (Appendix at 42-88) brings into stark relief the true purposes of the statute: to implement a belief that life begins at conception, and to discourage or prevent all abortions that the legislators thought they could reach—namely, those sought by poor women dependent on public funds for medical care.[88] The statute can be understood by those women only to mean that the state wants to prevent them from obtaining abortions, even at the expense of their health. Under *Roe* v. *Wade*, such a legislative purpose cannot be upheld.

CONCLUSION

For all the foregoing reasons, the District Court's judgment that the Illinois statute is unconstitutional should be affirmed.

Respectfully submitted,

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[88] "This Court need not in equal protection cases accept at face value assertions of legislative purposes, when an examination of the legislative scheme and its history demonstrates that the asserted purpose could not have been a goal of the legislation." Weinberger v. Wiesenfeld, 420 U.S. 636, 648 n.16 (1975) (citations omitted).